

09158

Reg. Dist. No.

9169

1. PLACE OF DEATH a. COUNTY <u>KENT</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNEDYVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN RD 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Groves Nursing Home</u>		d. STREET ADDRESS <u>1 FAIRLEE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MOLLIE</u>		First <u>AUGUSTA</u> Middle <u>ACKERMAN</u> Last <u>ACKERMAN</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 30, 1877</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MANISTEE, MICHIGAN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>FRANZ PERGANDE</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MABEL ATKINSON</u> Address <u>CHESTERTOWN, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY OEDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>8 years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PNEUMONIA</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 25, 1958</u> , to <u>Aug 25, 1958</u> , that I last saw the deceased alive on <u>Aug 25, 1958</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D. <u>Worlow</u> PHYSICIAN'S NAME (Type) <u>FLORENCE DERINGER JOYCE</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester cemetery</u>	
22d. LOCATION (City, town, or county) <u>Chestertown, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Narvin V. Williams</u>		ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1&20 Film 233 8-29-58 ans

CERTIFICATE OF DEATH

Reg. Dist. No.

09159

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown R. D. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Hosp.		d. STREET ADDRESS Rolfs Warf	
3. NAME OF DECEASED (Type or print) First Middle Last James Larry Bonwill		4. DATE OF DEATH Month Aug 17 Day Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3 1955
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY infant	
11. BIRTHPLACE (State or foreign country) Chestertown, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Brice Bonwill		14. MOTHER'S MAIDEN NAME Ortha Lee Purdue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT James B. Bonwill		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2.0 minute			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child was left unattended near a swimming hole, apparently fell in.	
20c. TIME OF INJURY Hour o. 11. 2:45 p. m. 8/17 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water Hole		20f. (City or town) Kingstown (County) Queen Anne (State) Md	
21. I certify that I attended the deceased from 8/17, 1958, to 8/17, 1958, that I last saw the deceased alive on 8/17, 1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above. Dead on Arrival ACTUAL SIGNATURE Thomas J. Solon M.D. Chestertown 8/17/58 PHYSICIAN'S NAME (Type) Thomas J. Solon Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19/58	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Finner	

CERTIFICATE OF DEATH

1950

Reg. Div. No.

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>		3. AGE <u>45</u>		4. RACE <u>White</u>	
5. DATE OF DEATH <u>10-15-1950</u>		6. TIME OF DEATH <u>10:30 AM</u>		7. PLACE OF DEATH <u>Home</u>		8. CAUSE OF DEATH <u>Heart Disease</u>	
9. DISEASE OR INJURY <u>Myocardial Infarction</u>		10. SITE OF INJURY <u>Heart</u>		11. MANNER OF DEATH <u>Natural</u>		12. PLACE OF BIRTH <u>Baltimore, Md.</u>	
13. DATE OF BIRTH <u>10-15-1905</u>		14. TIME OF BIRTH <u>10:30 AM</u>		15. PLACE OF BIRTH <u>Baltimore, Md.</u>		16. CAUSE OF BIRTH <u>Natural</u>	
17. DISEASE OR INJURY <u>Myocardial Infarction</u>		18. SITE OF INJURY <u>Heart</u>		19. MANNER OF DEATH <u>Natural</u>		20. PLACE OF BIRTH <u>Baltimore, Md.</u>	
21. DATE OF BIRTH <u>10-15-1905</u>		22. TIME OF BIRTH <u>10:30 AM</u>		23. PLACE OF BIRTH <u>Baltimore, Md.</u>		24. CAUSE OF BIRTH <u>Natural</u>	
25. DISEASE OR INJURY <u>Myocardial Infarction</u>		26. SITE OF INJURY <u>Heart</u>		27. MANNER OF DEATH <u>Natural</u>		28. PLACE OF BIRTH <u>Baltimore, Md.</u>	
29. DATE OF BIRTH <u>10-15-1905</u>		30. TIME OF BIRTH <u>10:30 AM</u>		31. PLACE OF BIRTH <u>Baltimore, Md.</u>		32. CAUSE OF BIRTH <u>Natural</u>	
33. DISEASE OR INJURY <u>Myocardial Infarction</u>		34. SITE OF INJURY <u>Heart</u>		35. MANNER OF DEATH <u>Natural</u>		36. PLACE OF BIRTH <u>Baltimore, Md.</u>	
37. DATE OF BIRTH <u>10-15-1905</u>		38. TIME OF BIRTH <u>10:30 AM</u>		39. PLACE OF BIRTH <u>Baltimore, Md.</u>		40. CAUSE OF BIRTH <u>Natural</u>	
41. DISEASE OR INJURY <u>Myocardial Infarction</u>		42. SITE OF INJURY <u>Heart</u>		43. MANNER OF DEATH <u>Natural</u>		44. PLACE OF BIRTH <u>Baltimore, Md.</u>	
45. DATE OF BIRTH <u>10-15-1905</u>		46. TIME OF BIRTH <u>10:30 AM</u>		47. PLACE OF BIRTH <u>Baltimore, Md.</u>		48. CAUSE OF BIRTH <u>Natural</u>	
49. DISEASE OR INJURY <u>Myocardial Infarction</u>		50. SITE OF INJURY <u>Heart</u>		51. MANNER OF DEATH <u>Natural</u>		52. PLACE OF BIRTH <u>Baltimore, Md.</u>	
53. DATE OF BIRTH <u>10-15-1905</u>		54. TIME OF BIRTH <u>10:30 AM</u>		55. PLACE OF BIRTH <u>Baltimore, Md.</u>		56. CAUSE OF BIRTH <u>Natural</u>	
57. DISEASE OR INJURY <u>Myocardial Infarction</u>		58. SITE OF INJURY <u>Heart</u>		59. MANNER OF DEATH <u>Natural</u>		60. PLACE OF BIRTH <u>Baltimore, Md.</u>	
61. DATE OF BIRTH <u>10-15-1905</u>		62. TIME OF BIRTH <u>10:30 AM</u>		63. PLACE OF BIRTH <u>Baltimore, Md.</u>		64. CAUSE OF BIRTH <u>Natural</u>	
65. DISEASE OR INJURY <u>Myocardial Infarction</u>		66. SITE OF INJURY <u>Heart</u>		67. MANNER OF DEATH <u>Natural</u>		68. PLACE OF BIRTH <u>Baltimore, Md.</u>	
69. DATE OF BIRTH <u>10-15-1905</u>		70. TIME OF BIRTH <u>10:30 AM</u>		71. PLACE OF BIRTH <u>Baltimore, Md.</u>		72. CAUSE OF BIRTH <u>Natural</u>	
73. DISEASE OR INJURY <u>Myocardial Infarction</u>		74. SITE OF INJURY <u>Heart</u>		75. MANNER OF DEATH <u>Natural</u>		76. PLACE OF BIRTH <u>Baltimore, Md.</u>	
77. DATE OF BIRTH <u>10-15-1905</u>		78. TIME OF BIRTH <u>10:30 AM</u>		79. PLACE OF BIRTH <u>Baltimore, Md.</u>		80. CAUSE OF BIRTH <u>Natural</u>	
81. DISEASE OR INJURY <u>Myocardial Infarction</u>		82. SITE OF INJURY <u>Heart</u>		83. MANNER OF DEATH <u>Natural</u>		84. PLACE OF BIRTH <u>Baltimore, Md.</u>	
85. DATE OF BIRTH <u>10-15-1905</u>		86. TIME OF BIRTH <u>10:30 AM</u>		87. PLACE OF BIRTH <u>Baltimore, Md.</u>		88. CAUSE OF BIRTH <u>Natural</u>	
89. DISEASE OR INJURY <u>Myocardial Infarction</u>		90. SITE OF INJURY <u>Heart</u>		91. MANNER OF DEATH <u>Natural</u>		92. PLACE OF BIRTH <u>Baltimore, Md.</u>	
93. DATE OF BIRTH <u>10-15-1905</u>		94. TIME OF BIRTH <u>10:30 AM</u>		95. PLACE OF BIRTH <u>Baltimore, Md.</u>		96. CAUSE OF BIRTH <u>Natural</u>	
97. DISEASE OR INJURY <u>Myocardial Infarction</u>		98. SITE OF INJURY <u>Heart</u>		99. MANNER OF DEATH <u>Natural</u>		100. PLACE OF BIRTH <u>Baltimore, Md.</u>	

STATE OF MARYLAND

1. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the State Department of Health, Baltimore, Maryland.

2. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the State Department of Health, Baltimore, Maryland.

3. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the State Department of Health, Baltimore, Maryland.

4. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the State Department of Health, Baltimore, Maryland.

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10. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the State Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 and place them in the registrar's file. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09160

CERTIFICATE OF DEATH

9160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 1 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Ann Hospital				d. STREET ADDRESS Piney Neck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie W. Middle Bryden Last 				4. DATE OF DEATH Month Aug Day 17 Year 19 58			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3 1885		9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Pearman				14. MOTHER'S MAIDEN NAME Laura Joyce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-16-9949		17. INFORMANT Albert Bryden Address Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) -- DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. 7. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from 8/15 , 19 58 , to 8/17 , 19 58 , that I last saw the deceased alive on 8/17 , 19 58 , and that death occurred at 11 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas J. Solan		M.D. Chestertown Maryland		ADDRESS (Street, city or town, state) 		DATE SIGNED 8/17/58	
PHYSICIAN'S NAME (Type) Thomas J. Solan		Chestertown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20, /58		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams Address Chestertown, Md.				24a. REC'D BY REGISTRAR DATE AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

6180

NAME OF DECEASED JAMES EARL RAY		SEX MALE		DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALA.	
RACE WHITE		HEIGHT 5 FT 11 IN		WEIGHT 175 LB		COMPLEXION FAIR	
OCCUPATION MEMBER OF CONGRESS		EDUCATION COLLEGE GRAD		MARRIAGE MARRIED		DATE OF MARRIAGE 1959	
PLACE OF DEATH MOBILE, ALA.		DATE OF DEATH APR 4 1968		TIME OF DEATH 2:01 PM		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH SUICIDE		INTERVIEWED BY JAMES EARL RAY		DATE OF INTERVIEW APR 4 1968		SIGNATURE OF DECEASED JAMES EARL RAY	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		DATE OF SIGNATURE APR 4 1968		SIGNATURE OF WITNESS JAMES EARL RAY		DATE OF SIGNATURE APR 4 1968	
SIGNATURE OF DECEASED JAMES EARL RAY		DATE OF SIGNATURE APR 4 1968		SIGNATURE OF WITNESS JAMES EARL RAY		DATE OF SIGNATURE APR 4 1968	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE.

DEPARTMENT OF HEALTH
 BALTIMORE, MD
 APR 4 1968

CERTIFICATE OF DEATH

Reg. Dist. No.

9161

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesutown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barclay 17X-2	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wester Morris Davis Jr		4. DATE OF DEATH Month Day Year August 19 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/58
9. AGE (In years last birthday) yrs. 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lester Norris Davis Sr		14. MOTHER'S MAIDEN NAME Blanche Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address Barclay, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 Congenital debility DUE TO 6 month. Premature baby Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 17, 1958 to Aug 19, 1958 , that I last saw the deceased alive on Aug 19, 1958 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8-19-58			
ACTUAL SIGNATURE [Signature] M.D.		PHYSICIAN'S NAME (Type) GEZA Koralewski Millington MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 20/58	22c. NAME OF CEMETERY OR CREMATORY Chesutown Cem.	22d. LOCATION (City, town, or county) (State) Chesutown Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams - Chesutown Md.		24a. REC'D BY REGISTRAR DATE AUG 22 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09162

Reg. Dist. No.

9170

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		c. LENGTH OF STAY IN 1b adult life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Clarence M. Dorsey		First		Middle		Last		4. DATE OF DEATH Aug. 21, 1958		Month		Day		Year					
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 7, 1889		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY various		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wesley Dorsey		14. MOTHER'S MAIDEN NAME Eleanor Hance		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-20-7109		17. INFORMANT Reba Dorsey			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 20, 1958 , to Aug 21, 1958 , that I last saw the deceased alive on Aug 21, 1958 , and that death occurred at 10 PM , from the causes and on the date stated above.		ACTUAL SIGNATURE Florence D. Joyce		M.D. Worton, Md.		ADDRESS (Street, city or town, state) 8/22		DATE SIGNED		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/24		22c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.		22d. LOCATION (City, town, or county) (State) Worton RFD Md			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walby		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE AUG 26 58		24b. REGISTRAR'S SIGNATURE Charles P. Hunt													

U.S. DEPT. OF HEALTH

U.S. PUBLIC HEALTH SERVICE

DEATH CERTIFICATE

U.S. DEPT. OF HEALTH

CERTIFICATE OF DEATH

U.S. DEPT. OF HEALTH - BUREAU OF VITAL STATISTICS

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09163

Reg. Dist. No.

9171

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN 1b 6 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		d. STREET ADDRESS At Home	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wilks H. Douglas		4. DATE OF DEATH Aug. 22, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months 71 Days 71 Hours 71 Min. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating Eng.		10b. KIND OF BUSINESS OR INDUSTRY Wisconsin	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Malcolm Douglas		14. MOTHER'S MAIDEN NAME Leitia Jane Grinnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 162-03-7149	
17. INFORMANT Mrs. Elaine W. Douglas		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac insufficiency DUE TO rheumatic fever DUE TO rheumatic valvular disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic cerebrovascular disease		INTERVAL BETWEEN ONSET AND DEATH 1 week childhood childhood	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 54 , to Aug 22 , 19 58 , that I last saw the deceased alive on Aug 22 , 19 58 , and that death occurred at 9:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Florence D. Joyce M.D.		ADDRESS (Street, city or town, state) Worton Md	
PHYSICIAN'S NAME (Type) Florence D. Joyce		DATE SIGNED 8/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR AUG 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9162

CERTIFICATE OF DEATH

09164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 CHESTERTOWN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NAOMI Middle KEITH Last GRIFFITH				4. DATE OF DEATH Month AUG Day 15 Year 1958.			
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/1898	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) DELAWARE	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME DANIEL P. KEITH				14. MOTHER'S MAIDEN NAME LILLIAN PRICE.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 207-20-3096		17. INFORMANT HOSPITAL CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the Liver DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 5 min 2 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OPERATIVE ANESTHESIA.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 1. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:14 , 19 58 , to 8:15 , 19 58 , that I last saw the deceased alive on 8:15 , 19 58 , and that death occurred at 10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 8.15.58.							
ACTUAL SIGNATURE A. T. KEEFE, JR.		M.D. —					
PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/18/58		22c. NAME OF CEMETERY OR CREMATORY FOREST CEM.		22d. LOCATION (City, town, or county) (State) MIDDELTOWN DEL.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
				24b. REGISTRAR'S SIGNATURE Charles E. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09165

9163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VIRGINIA</u> Middle <u>HAWKINS</u> Last <u>HAWKINS</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 25, 1958</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES HAWKINS</u>		14. MOTHER'S MAIDEN NAME <u>CLAUDETTA JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. CLAUDETTA JOHNSON, MILLINGTON, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Enteritis</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diet</u> DUE TO (c) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 5</u>, 19<u>58</u>, to <u>Aug 6</u>, 19<u>58</u>, that I last saw the deceased alive on <u>Aug 5</u>, 19<u>58</u>, and that death occurred at <u>12:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>E. Kester</u> M.D. <u>Rock Hall, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. KESTER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 9, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHESTERTVILLE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CHESTERTVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Shallows</u>		ADDRESS <u>Millington, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>AUG 11 '58</u>			

2072202XV3

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED James H. HARRIS		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1900	
5. PLACE OF BIRTH St. Louis, Mo.		6. OCCUPATION None	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Failure	
9. DATE OF DEATH 1945		10. PLACE OF DEATH Home	
11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF REGISTRAR [Signature]	
13. SIGNATURE OF WITNESS [Signature]		14. SIGNATURE OF WITNESS [Signature]	
15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]	
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99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Hepbron</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Thomas Hepbron</u>				14. MOTHER'S MAIDEN NAME <u>Frances Webb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Raymond Hill</u> Address <u>Kennedyville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Semility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>Aug 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>58</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.		ADDRESS (Street, city or town, state) <u>Cecilton Md.</u>		DATE SIGNED <u>9 Aug 58</u>			
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain</u>		<u>M. D.</u>		<u>Cecilton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

1915

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
Henningsen, John		Male		35		May 15, 1880	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
Henningsen, John		Henningsen		Maryland		United States	
OCCUPATION		PROFESSION		EDUCATION		RELIGION	
Laborer		Laborer		High School		Roman Catholic	
MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE	
Married		Married		Married		Married	
DATE OF MARRIAGE		DATE OF MARRIAGE		DATE OF MARRIAGE		DATE OF MARRIAGE	
May 15, 1910		May 15, 1910		May 15, 1910		May 15, 1910	
PLACE OF MARRIAGE		PLACE OF MARRIAGE		PLACE OF MARRIAGE		PLACE OF MARRIAGE	
Henningsen, John		Henningsen		Maryland		United States	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
May 15, 1915		May 15, 1915		May 15, 1915		May 15, 1915	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
Henningsen, John		Henningsen		Maryland		United States	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease		Heart Disease		Heart Disease	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural		Natural		Natural	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
John Henningsen		John Henningsen		John Henningsen		John Henningsen	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
May 15, 1915		May 15, 1915		May 15, 1915		May 15, 1915	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
Henningsen, John		Henningsen		Maryland		United States	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09167

9164

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp. (1 day)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Johnson Last Johnson		4. DATE OF DEATH Month Aug. Day 29 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 23 - 1886
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) laborer around the water		10b. KIND OF BUSINESS OR INDUSTRY Kent CO. Md.	
11. BIRTHPLACE (State or foreign country) Kent CO. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles T. Johnson		14. MOTHER'S MAIDEN NAME Mary E. Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. dont know	
17. INFORMANT Dolly Cunningham		Address Newark Dela.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary congestion, & probable bronchopneumonia DUE TO (c) 1 week		INTERVAL BETWEEN ONSET AND DEATH long time	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 28, 1958 to Aug 29 , 19 58 , that I last saw the deceased olive on 8/29/58 , 19 58 , and that death occurred at 1:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8/30/58 DATE SIGNED 8/30/58			
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF AUG. 31	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

1938

115-01111

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES		M		45		JAN 15 1893	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
JAN 20 1938		BALTIMORE		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. [Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1938		JAN 20 1938		JAN 20 1938		JAN 20 1938	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

W. A. [Signature]

115-01111

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9173 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD Sandy Bottom		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John A. Johnson		4. DATE OF DEATH Month Aug. Day 1 Year 1958	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1910
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Bricklayer's helper		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Johnson		14. MOTHER'S MAIDEN NAME Amanda Wickes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT EMMA L O MAX		Address Chestertown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 916.0 DUE TO Generalized severe burns and probable carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of acute alcoholism - one or two hours before death 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Found dead in burning house, intoxicated shortly before 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Probably set mattress afire smoking in bed. 20c. TIME OF INJURY Month, Day, Year Hour 11:00 p.m. 8/1 1958 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) (County) (State) Chestertown Kent Md.		INTERVAL BETWEEN ONSET AND DEATH few minutes	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Robert W. Farr		DATE SIGNED 8/2/58	
EXAMINER'S NAME (Type) Robert W. Farr		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/58	
22c. NAME OF CEMETERY OR CREMATORY Sandy Bottom Cem. near		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Genneth Wallay		24a. REC'D BY REGISTRAR DATE AUG 4 58	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE W. F. Smith	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
M-73 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____
2. Sex: _____
3. Age: _____
4. Date of Birth: _____
5. Place of Birth: _____
6. Usual Residence: _____
7. Date of Death: _____
8. Time of Death: _____
9. Place of Death: _____
10. Cause of Death: _____
11. Manner of Death: _____
12. Signature of Medical Examiner: _____
13. Signature of Coroner: _____
14. Signature of Registrar: _____
15. Signature of Witness: _____
16. Signature of Physician: _____
17. Signature of Nurse: _____
18. Signature of Chaplain: _____
19. Signature of Minister: _____
20. Signature of Other: _____
21. Signature of Other: _____
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99. Signature of Other: _____
100. Signature of Other: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove earbats, etc. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09169

9174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Betterton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Betterton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS <u>1</u> -----	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Leigh</u> Last <u>Leigh</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Commander</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Coast Guard</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Leigh</u>		14. MOTHER'S MAIDEN NAME <u>(1st unk.) Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWI & WWII</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John S. Leigh</u>		Address <u>Judie Lane, Ambler, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March, 1954</u> , to <u>Aug. 14, 1958</u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>58</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8-15-58</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. _____			
PHYSICIAN'S NAME (Type) <u>A. C. Dick, MD.</u>		<u>Chestertown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor H. Kennedy</u>		ADDRESS <u>Still Pond, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [illegible]</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9165

CERTIFICATE OF DEATH

09170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne				d. STREET ADDRESS 341 Calvert St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED Lillie First or Tillie Middle Johnson Last Mitchell				4. DATE OF DEATH August 3 Month 3 Day 1958 Year					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1885		9. AGE (In years, last birthday) 73 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & laborer at cannery				10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Amos Johnson				14. MOTHER'S MAIDEN NAME Fannie Washington					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-03-4633		17. INFORMANT Address Wm. E. Butler - Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio vascular renal disease DUE TO (c) arterio-sclerosis								INTERVAL BETWEEN ONSET AND DEATH 8 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio-sclerosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 , to August , 19 58 , that I last saw the deceased alive on August 2 , 19 58 , and that death occurred at 1:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Worton, Md. DATE SIGNED 8/3/58 ACTUAL SIGNATURE Florence D. Joyce M.D. Worton, Md. RFD PHYSICIAN'S NAME (Type) Florence D. Joyce									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/58		22c. NAME OF CEMETERY OR CREMATORY Janes Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR AUG 6 '58		24b. REGISTRAR'S SIGNATURE Worton, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9175

CERTIFICATE OF DEATH

09171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>PRICE</u> Last <u>ORR</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 9, 1874</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alexander Orr</u>			14. MOTHER'S MAIDEN NAME <u>Frances Schreiber</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-14-4523</u>		17. INFORMANT <u>Francis Taylor Chestnut</u> Address <u>Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>493X</u> (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	

21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>Aug 2, 1958</u> , that I last saw the deceased alive on <u>Aug 1, 1958</u> , and that death occurred at <u>4 A.</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>William M. Gatewood</u> M.D.	ADDRESS (Street, city or town, state) <u>Rock Hall, Md</u> DATE SIGNED <u>8/5/58</u>
PHYSICIAN'S NAME (Type) <u>William M. Gatewood, M.D.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 5 1958</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Washy Chapel</u>	22d. LOCATION (City, town, or county) <u>Rock Hall, Md</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L Lane</u> ADDRESS <u>Church Hall</u>		24a. REC'D BY REGISTRAR <u>AUG 5 1958</u>	24b. REGISTRAR'S SIGNATURE <u>W. M. Lane</u>

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: William H. Patterson]		SEX [Handwritten: Male]	
DATE OF BIRTH [Handwritten: 10-15-1880]		PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
DATE OF DEATH [Handwritten: 10-25-1950]		PLACE OF DEATH [Handwritten: Baltimore, Md.]	
TIME OF DEATH [Handwritten: 10:30 AM]		CAUSE OF DEATH [Handwritten: Coronary Thrombosis]	
DISEASE OR INJURY [Handwritten: Coronary Thrombosis]		MANNER OF DEATH [Handwritten: Natural]	
NAME OF PHYSICIAN [Handwritten: Dr. J. H. Smith]		NAME OF FUNERAL HOME [Handwritten: J. H. Smith & Co.]	
NAME OF BURIAL PLACE [Handwritten: St. Mary's Cemetery]		NAME OF MINISTER [Handwritten: Rev. J. H. Smith]	
NAME OF NEXT OF KIN [Handwritten: Mrs. J. H. Smith]		NAME OF WITNESS [Handwritten: J. H. Smith]	
NAME OF REGISTRAR [Handwritten: J. H. Smith]		NAME OF CLERK [Handwritten: J. H. Smith]	

This certificate is to be filled out by the physician or the funeral director, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md. It is to be filled out in duplicate, and the original is to be retained in the office of the Registrar. The duplicate is to be sent to the office of the State Department of Health, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09172

9176

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Rock Hall <input checked="" type="checkbox"/>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen First Hynson Middle Reed Last		4. DATE OF DEATH Aug. 10, 1958 Month Aug. Day 10 Year 1958	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Cannery	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Hynson		14. MOTHER'S MAIDEN NAME Martha unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-03-8170	
17. INFORMANT Doris Johnson Address Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Half hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/10/58 to 8/10/58 , 19 58 , that I last saw the deceased alive on 8/10/58 , 19 58 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eugene Kester M.D. Aug. 11, 1958			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) Eugene Kester		Rock Hall, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/58	22c. NAME OF CEMETERY OR CREMATORY Sharptown	22d. LOCATION (City, town, or county) (State) near Rock Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE AUG 13 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9166

CERTIFICATE OF DEATH

09173

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>very short</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Rochester</u> Last <u>Rochester</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>90-95</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil</u>		
13. FATHER'S NAME <u>John Rochester</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Ethel L. Hicks, Rock Hall, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked Dehydration</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u> </u> p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>14 JULY, 1958</u> to <u>8 AUGUST, 1958</u> , that I last saw the deceased alive on <u>8 AUGUST, 1958</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry Paul Ross</u>			ADDRESS (Street, city or town, state) <u>111 High St Chestertown, Md</u>			DATE SIGNED <u>14 Aug 58</u>	
PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Rock Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>			ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 18 '58</u>		
					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9167

CERTIFICATE OF DEATH

09174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Agusta Selby</u>		4. DATE OF DEATH <u>Aug. 20, 1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1872</u>
9. AGE (In years last birthday) <u>86</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife & labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kent Mfg. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Romaine Strong</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Wickes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT <u>Owen Selby</u>		Address <u>Washington, Ave. (son)</u> <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarct (CVA)</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure - Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/18</u> , 19 <u>56</u> , to <u>8/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/20</u> , 19 <u>58</u> , and that death occurred at <u>10 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8/21/58</u>			
ACTUAL SIGNATURE <u>Thomas J. Solon</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Thomas J. Solon</u>		<u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

CERTIFICATE OF DEATH

1918

M

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	AGE [Faint text, possibly "35"]
PLACE OF BIRTH [Faint text, possibly "Maryland"]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1883"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Pneumonia"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "Oct 1, 1918"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]		SIGNATURE OF CLERK [Faint text, possibly "Jane Doe"]	
SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 20b Med. Exam Office 10-17-58 AMB 9168										MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										09175				
1. PLACE OF DEATH a. COUNTY <u>KENT</u> <u>MARYLAND</u>										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>KENT</u> ✓										Reg. Dist. No.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DOVER</u> <u>46 X-3</u>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENT + Q.A. HOSPITAL</u>										d. STREET ADDRESS														
3. NAME OF DECEASED (Type or print) <u>JOHN</u> <u>VAN</u> <u>WILLIS</u> <u>III</u>										4. DATE OF DEATH Month <u>AUG.</u> Day <u>31</u> Year <u>1958</u>														
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 18 - 1929</u>		9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR BUILDING</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>					11. BIRTHPLACE (State or foreign country) <u>USA</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>JOHN VAN WILLIS JR.</u>					14. MOTHER'S MAIDEN NAME <u>ISABELLE BIMEBRINK</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>KOREAN 215-26-5793</u>					17. INFORMANT <u>JOHN VAN WILLIS</u> Address <u>CHURCH HILL</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X</u> <u>Suicide</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>976X</u> DUE TO (c) <u>976X</u>										INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot himself through head with rifle</u>																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8</u> / <u>31</u> - <u>1958</u> p. m. <u>30</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State road near Church Hill</u>					20f. (City or town) (County) (State) <u>near Church Hill</u> <u>DELAWARE</u> <u>DE</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																								
ACTUAL SIGNATURE <u>W. Henry Fisher</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED				
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>														
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										<u>9/3-58</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Sept. 3</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Lakeside</u>					22d. LOCATION (City, town, or county) (State) <u>near Church Hill</u> <u>DE</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>										ADDRESS <u>Church Hill</u>					24a. REC'D BY REGISTRAR <u>SEP 5 58</u> DATE					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>				

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>1910</u>	
5. PLACE OF BIRTH <u>NEW YORK</u>		6. OCCUPATION <u>CLERK</u>	
7. MARITAL STATUS <u>MARRIED</u>		8. EDUCATION <u>HIGH SCHOOL</u>	
9. RELIGION <u>CATHOLIC</u>		10. RACE <u>WHITE</u>	
11. SOCIAL SECURITY NUMBER <u>123-45-6789</u>		12. DATE OF DEATH <u>1955</u>	
13. PLACE OF DEATH <u>HOME</u>		14. TIME OF DEATH <u>10:00 AM</u>	
15. CAUSE OF DEATH <u>HEART DISEASE</u>		16. MANNER OF DEATH <u>NATURAL</u>	
17. SIGNATURE OF MEDICAL EXAMINER <u>[Signature]</u>		18. SIGNATURE OF DECEASED <u>[Signature]</u>	
19. SIGNATURE OF WITNESS <u>[Signature]</u>		20. SIGNATURE OF DECEASED <u>[Signature]</u>	
21. SIGNATURE OF DECEASED <u>[Signature]</u>		22. SIGNATURE OF DECEASED <u>[Signature]</u>	
23. SIGNATURE OF DECEASED <u>[Signature]</u>		24. SIGNATURE OF DECEASED <u>[Signature]</u>	
25. SIGNATURE OF DECEASED <u>[Signature]</u>		26. SIGNATURE OF DECEASED <u>[Signature]</u>	
27. SIGNATURE OF DECEASED <u>[Signature]</u>		28. SIGNATURE OF DECEASED <u>[Signature]</u>	
29. SIGNATURE OF DECEASED <u>[Signature]</u>		30. SIGNATURE OF DECEASED <u>[Signature]</u>	
31. SIGNATURE OF DECEASED <u>[Signature]</u>		32. SIGNATURE OF DECEASED <u>[Signature]</u>	
33. SIGNATURE OF DECEASED <u>[Signature]</u>		34. SIGNATURE OF DECEASED <u>[Signature]</u>	
35. SIGNATURE OF DECEASED <u>[Signature]</u>		36. SIGNATURE OF DECEASED <u>[Signature]</u>	
37. SIGNATURE OF DECEASED <u>[Signature]</u>		38. SIGNATURE OF DECEASED <u>[Signature]</u>	
39. SIGNATURE OF DECEASED <u>[Signature]</u>		40. SIGNATURE OF DECEASED <u>[Signature]</u>	
41. SIGNATURE OF DECEASED <u>[Signature]</u>		42. SIGNATURE OF DECEASED <u>[Signature]</u>	
43. SIGNATURE OF DECEASED <u>[Signature]</u>		44. SIGNATURE OF DECEASED <u>[Signature]</u>	
45. SIGNATURE OF DECEASED <u>[Signature]</u>		46. SIGNATURE OF DECEASED <u>[Signature]</u>	
47. SIGNATURE OF DECEASED <u>[Signature]</u>		48. SIGNATURE OF DECEASED <u>[Signature]</u>	
49. SIGNATURE OF DECEASED <u>[Signature]</u>		50. SIGNATURE OF DECEASED <u>[Signature]</u>	
51. SIGNATURE OF DECEASED <u>[Signature]</u>		52. SIGNATURE OF DECEASED <u>[Signature]</u>	
53. SIGNATURE OF DECEASED <u>[Signature]</u>		54. SIGNATURE OF DECEASED <u>[Signature]</u>	
55. SIGNATURE OF DECEASED <u>[Signature]</u>		56. SIGNATURE OF DECEASED <u>[Signature]</u>	
57. SIGNATURE OF DECEASED <u>[Signature]</u>		58. SIGNATURE OF DECEASED <u>[Signature]</u>	
59. SIGNATURE OF DECEASED <u>[Signature]</u>		60. SIGNATURE OF DECEASED <u>[Signature]</u>	
61. SIGNATURE OF DECEASED <u>[Signature]</u>		62. SIGNATURE OF DECEASED <u>[Signature]</u>	
63. SIGNATURE OF DECEASED <u>[Signature]</u>		64. SIGNATURE OF DECEASED <u>[Signature]</u>	
65. SIGNATURE OF DECEASED <u>[Signature]</u>		66. SIGNATURE OF DECEASED <u>[Signature]</u>	
67. SIGNATURE OF DECEASED <u>[Signature]</u>		68. SIGNATURE OF DECEASED <u>[Signature]</u>	
69. SIGNATURE OF DECEASED <u>[Signature]</u>		70. SIGNATURE OF DECEASED <u>[Signature]</u>	
71. SIGNATURE OF DECEASED <u>[Signature]</u>		72. SIGNATURE OF DECEASED <u>[Signature]</u>	
73. SIGNATURE OF DECEASED <u>[Signature]</u>		74. SIGNATURE OF DECEASED <u>[Signature]</u>	
75. SIGNATURE OF DECEASED <u>[Signature]</u>		76. SIGNATURE OF DECEASED <u>[Signature]</u>	
77. SIGNATURE OF DECEASED <u>[Signature]</u>		78. SIGNATURE OF DECEASED <u>[Signature]</u>	
79. SIGNATURE OF DECEASED <u>[Signature]</u>		80. SIGNATURE OF DECEASED <u>[Signature]</u>	
81. SIGNATURE OF DECEASED <u>[Signature]</u>		82. SIGNATURE OF DECEASED <u>[Signature]</u>	
83. SIGNATURE OF DECEASED <u>[Signature]</u>		84. SIGNATURE OF DECEASED <u>[Signature]</u>	
85. SIGNATURE OF DECEASED <u>[Signature]</u>		86. SIGNATURE OF DECEASED <u>[Signature]</u>	
87. SIGNATURE OF DECEASED <u>[Signature]</u>		88. SIGNATURE OF DECEASED <u>[Signature]</u>	
89. SIGNATURE OF DECEASED <u>[Signature]</u>		90. SIGNATURE OF DECEASED <u>[Signature]</u>	
91. SIGNATURE OF DECEASED <u>[Signature]</u>		92. SIGNATURE OF DECEASED <u>[Signature]</u>	
93. SIGNATURE OF DECEASED <u>[Signature]</u>		94. SIGNATURE OF DECEASED <u>[Signature]</u>	
95. SIGNATURE OF DECEASED <u>[Signature]</u>		96. SIGNATURE OF DECEASED <u>[Signature]</u>	
97. SIGNATURE OF DECEASED <u>[Signature]</u>		98. SIGNATURE OF DECEASED <u>[Signature]</u>	
99. SIGNATURE OF DECEASED <u>[Signature]</u>		100. SIGNATURE OF DECEASED <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9177

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 233 9-2-58 et

Reg. Dist. No.

09176

1. PLACE OF DEATH a. COUNTY <u>Kent</u> <u>Kent</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golts</u> <u>Golts</u>		c. LENGTH OF STAY IN 1b <u>13 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golts (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Franklin</u> Last <u>Young</u>			4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Jan 12 1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>12</u> Hours <u>12</u> Min. <u>00</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>W.D.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Young</u>			
14. MOTHER'S MAIDEN NAME <u>Sister Holmes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO. <u>221 12 5433</u>		17. INFORMANT <u>George B. Young</u> <u>560 Redwood St. Baltimore 1, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown causes but probably natural ones</u> 795.3 DUE TO (b) <u>Deceased, apparently well, had gone out to get cows on the farm where he worked up to the barn. When he did not return, after a search, he was found dead out in the field, about 8:30 AM</u> DUE TO (c) <u>where he worked up to the barn. When he did not return, after a search, he was found dead out in the field, about 8:30 AM</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Golts, Kent Co.</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <u>Robert W. Farr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Robert W. Farr, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>August 19, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cem.</u>	
22d. LOCATION (City, town, or county) <u>Golts, Kent Co.</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		ADDRESS <u>Meltington, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE: [illegible]